

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Alternate Phone: _____
 Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

<p>Multiple Sclerosis:</p> <p><input type="checkbox"/> G35 Multiple Sclerosis <input type="checkbox"/> G35 Relapsing/Remitting <input type="checkbox"/> G35 Primary Progressive <input type="checkbox"/> G35 Secondary Progressive <input type="checkbox"/> Other: _____</p> <p>Number of Relapses the past year: _____ Date of Diagnosis: _____ Date of last MRI: _____ MRI Changes: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">DIAGNOSIS/CLINICAL INFORMATION</p> <p>Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart</p> <p>Prior Treatment: <input type="checkbox"/> Avonex® <input type="checkbox"/> Copaxone® <input type="checkbox"/> Rebif® <input type="checkbox"/> Betaseron® <input type="checkbox"/> Extavia® <input type="checkbox"/> Other: _____</p> <p>Treatment Response: _____ Treatment Dates: _____ Patient Weight: _____ kg <input type="checkbox"/> lbs Height: _____ cm <input type="checkbox"/> in Allergies: _____ Lab Data: _____ Concomitant Medications: _____ Comorbidities: _____</p>
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PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
<input type="checkbox"/> Avonex® (Biogen Idec)	<input type="checkbox"/> 30mcg Syringe <input type="checkbox"/> 30mcg Pen <input type="checkbox"/> 30mcg Vial			
<input type="checkbox"/> Betaseron® (Bayer)	<input type="checkbox"/> 0.3mg Vial & Diluent			
<input type="checkbox"/> Copaxone® (Teva)	<input type="checkbox"/> 20mg Syringe <input type="checkbox"/> 40mg Syringe			
<input type="checkbox"/> Extavia® (Novartis)	<input type="checkbox"/> 0.3mg Vial & Diluent			
<input type="checkbox"/> Gilenya® (Novartis)	<input type="checkbox"/> 0.5mg Capsule			
<input type="checkbox"/> Glatopa® (Sandoz)	<input type="checkbox"/> 20mg per 1mL Syringe			
<input type="checkbox"/> Rebif® (EMD Serono)	<input type="checkbox"/> Titration Pack <input type="checkbox"/> Rebidose® AutoInjector Titration			
	<input type="checkbox"/> 22mcg Syringe <input type="checkbox"/> Rebidose® AutoInjector 22mcg			
	<input type="checkbox"/> 44mcg Syringe <input type="checkbox"/> Rebidose® AutoInjector 44mcg			

ADDITIONAL COMMENTS:

STAMP SIGNATURE NOT ALLOWED

PHYSICIAN SIGNATURE REQUIRED

X _____ X _____
 PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

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